MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-7644-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Pacific Employers Insurance Co. Box 15	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 039CBANS3057

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/09/02	**12/21/02**	**97139-PH**	**$152.00**	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 06/05/03 states in part, "…The attached was paid by carrier as a partial payment and was sent back for reconsideration based on usual and customary in our area which TWCC MDR has determined to be $35.00. However, carrier has not responded to our request as required by TWCC MFG".

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a position statement with their response.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97139-PH for dates of service 12/09/02, 12/10/02, 12/13/02, 12/17/02, 12/19/02, and 12/21/02 denied as "CUFX – F – Reimbursement is based on the maximum allowable fee for this procedure." Per the 1996 Medical Fee Guideline, Medicine Ground Rule CPT descriptor, CPT Code 97139 is a DOP code. The requestor billed $50.00 for each date of service and the respondent paid $22.00 for each date of service with an amount in dispute of $28.00 per date of service. Per Rule 133.307(g)(3)(D) the requestor did not submit convincing evidence (i.e. redacted EOBs) that support additional reimbursement. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
12/9/2002 -							
12/21/2002	97139-PH	$152.00	$0.00				
					Total Left Column:		$152.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

	Marguerite Foster	December 22, 2004
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____